Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: THE SAN ANTONIO ORTHOPAEDIC SURGERY CENTER PO BOX 34533 SAN ANTONIO TX 78265	MFDR Tracking #: M4-04-3560-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: TASB RISK MGMT FUND Box #: 47	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Rationale for Increased Reimbursement: "Not paid fair and reasonable."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Medical Records
5. Total Amount Sought - $803.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "M"

Principal Documentation:

1. DWC 60 Package

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
8/5/2004	Ambulatory Surgical Care (ASC) Services for CPT codes 25000 & 20605	Not Applicable	$803.00	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. This request for medical fee dispute resolution was received by the Division on November 14, 2003. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on November 21, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.

2. Division rule at 28 TAC §134.800, effective July 15, 2000, requires ambulatory surgical centers to submit bills using the UB-92 billing form for institution services.

3. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, requires that services not identified in a fee

guideline shall be reimbursed at fair and reasonable rates.

4. Texas Labor Code §413.011 requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.
5. Division rule at 28 TAC §133.401, effective August 1, 1997, sets forth the facility fee guidelines for Acute Care Inpatient Hospitals.
6. Division rule at 28 TAC §133.307, effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, sets out the procedure for medical fee dispute resolution.
7. Division rule at 28 TAC §133.304, effective July 15, 2000, 25 TexReg 2115, requires the insurance carrier to develop and consistently apply a methodology to determine fair and reasonable reimbursement.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 6/10/2003

   - M-No MAR

   Explanation of benefits dated 11/5/2003

   - M-No MAR

Issues

1. What is the applicable rule for reimbursement?
2. Is the requestor entitled to additional reimbursement for ASC services for CPT codes 25000 and 20605?

Findings

1. Division rule at 28 TAC §134.401(a)(4) states "Ambulatory/outpatient surgical care is not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursement." Therefore, Division rule at 28 TAC §134.1 is the applicable rule governing reimbursement for the disputed services.

   Division rule at 28 TAC §134.1 requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

2. Division rule at 28 TAC §133.307(g)(3)(C)(iii) requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the requestor did not state how the Texas Labor Code and Division rules impact the disputed fee issues. The Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iii).

   Division rule at 28 TAC §133.307(g)(3)(C)(iv) requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).

   Division rule at 28 TAC §133.307(g)(3)(D) requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

   - The requestor's rationale for increased reimbursement taken from the *Table of Disputed Services* states "Not paid fair and reasonable."
   - The requestor does not discuss or explain how additional payment of $803.00 would result in a fair and reasonable reimbursement.
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.

- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
- The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services involved in this dispute.

Authorized Signature	Medical Fee Dispute Resolution Officer	June 16, 2010 Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.